1952

An Analysis of the Case Records of Forty-Four Community Patients Known to the Chicago Community Clinic from July 1947 Through June 1951

Helen Sankofski
Loyola University Chicago

AN ANALYSIS OF THE CASE RECORDS OF FORTY-FOUR COMMUNITY PATIENTS KNOWN TO THE CHICAGO COMMUNITY CLINIC FROM JULY 1947 THROUGH JUNE 1951

by

Helen Sankofski

A Thesis Submitted to the Faculty of the School of Social Work of Loyola University in Partial Fulfillment of the Requirements for the Degree of Master of Social Work

June

1952

TABLE OF CONTENTS

CHAPTER		Page
INTRODUCTION		1
I.	REVIEW OF RELATED LITERATURE	1
	Proper referral preparation--Focus of the intake interview--Worker's role in the team.	
II.	SERVICES PROVIDED BY THE CLINIC	5
	Functions of the clinic--Staff composition and functions--Intake process--Consultation and treatment.	
III.	FACTORS RELATED TO EFFECTIVE TREATMENT	11
	Sources of referral--Patient's formulation of his problem and motivation for treatment--Diagnostic categories--Duration of treatment--Nature of termination of patient-clinic contact.	
SUMMARY AND CONCLUSIONS		29
BIBLIOGRAPHY		31
APPENDIX		33

LIST OF TABLES

TABLE		Page
I	RESULTS IN RESPECT TO SOCIAL RELATIONSHIPS OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT	14
II	RESULTS IN RESPECT TO OCCUPATION OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT	15
III	RESULTS IN RESPECT TO PSYCHIATRIC PROBLEM OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT.	16
IV	COMPOSITE PICTURE OF TABLES II, III, and IV	18
V	SOURCES OF REFERRAL	21
VI	PATIENTS VIEW OF HIS PROBLEM AS RELATED TO EFFECTIVENESS OF TREATMENT.	23
VII	DISTRIBUTION OF FORTY-FOUR TREATMENT CASES ACCORDING TO DIAGNOSTIC TYPE AND RATE OF EFFECTIVE SERVICE	24
VIII	FREQUENCY OF CLINIC VISITS MADE BY FORTY-FOUR TREATED PATIENTS	26
IX	MANNER OF TERMINATING PATIENT-CLINIC CONTACT AS RELATED TO EFFECTIVENESS OF TREATMENT	27

INTRODUCTION

This study is based on an analysis of the case records[1] of 44 community patients[2] known to the Chicago Community Clinic[3] from July 1947 through June 1951. The purpose of the study is to determine the factors which seem to be significantly related to effective treatment.

The following information about the patients in the study group was secured from the records in the clinic (see Appendix): 1) the source of referral; 2) the problem presented by the patient at intake; 3) the staff diagnosis; 4) the staff treatment plan or recommendations; 5) the services of the clinic given to the patient.

The records also revealed the persons or agency seen in collateral interviews, the number of treatment interviews, the duration of treatment, why treatment ended, and the results of treatment; that is, the changes noted in the record as a result of the patient-clinic contact.

---

1. There were 160 records of community patients in the files. Fifty-six of these were still active at the time this study began; thirty-three inquired about service but actually never appeared for an appointment; twenty-seven received consultation service only; and forty-four patients received treatment. This last category comprises the study group of the thesis.

2 Community patients as distinguished from the conditionally discharged post psychotic patients routinely referred to the clinic by state hospitals for supervision, are individuals who have never been in state hospitals and who require psychiatric help.

3 In January 1952 Chicago Community Clinic was merged with the Veterans Rehabilitation Center; both are now known as the Chicago Mental Health Centers.

The study will be presented in the following manner: a review of related literature will be found in Chapter I; in Chapter II an attempt will be made to give in detail the services of the Chicago Community Clinic, and the third chapter will discuss the factors related to effective treatment.

CHAPTER I

REVIEW OF RELATED LITERATURE

Current literature repeatedly expresses the prime importance of properly preparing the patient at the source of referral. This statement coincides with the findings of the New York City Committee on Mental Hygiene which states that

> The prospects for effective therapy are significantly influenced by the patient's approach to the clinic and the clinic's approach to the patient. The approach, in turn, is strongly conditioned by the selection of patients for referral, the preparation of the patients referred, and the preparation of the clinic to which he is sent.[1]

That study further emphasizes the obvious fact that psychiatric clinics are overcrowded and, therefore, it is necessary to have selectivity in the referral process. It concludes that the efficient use of the facilities of a psychiatric clinic demands of the referring agency an attempt to select judiciously the patients to be referred in terms of the patient's capacity to utilize the help, and of the clinic's capacity to render the kind of help needed.[2]

The foregoing thinking is further substantiated by a report of the

---

1 New York City Committee on Mental Hygiene, The Functioning of Psychiatric Clinics in New York City.

2 Ibid., 21.

same committee when it made a study of the psychiatric needs in rehabilitation.

> Adequate preparation of the patient obviously demands adequate knowledge on the part of the referring agency. Successful referrals require that the various clinics interpret to the referring agencies the nature, and the limitations, of the services they can offer to patients.[3]

Therefore, it is obvious that the preparation of the patient for the services he is to receive is an intrinsic part of the referral service. It must be made clear to him that he is being referred in order to accept psychiatric treatment and not to secure a job placement. The dominant question, essential to the effectiveness of treatment, is whether or not the patient is receptive to this type of service.

Even by following the foregoing suggestions of adequate preparation of the patient, serious trouble may develop unless the social worker in the intake interview establishes the kind of relationship that may lead to either the rejection or acceptance of therapy. Celia Brody, in her paper, "Helping a Client Move into Psychiatric Treatment" states that:

> Without a meaningful relationship, the client is unable to develop enough trust in the worker to bear the pain inherent in the need for help and in the self-revelation accompanying any reaching out for help.[4]

The review of related literature further reveals that the psychiatric social worker in the intake interview focuses on obtaining a generalized

---

3 New York City Committee on Mental Hygiene, Psychiatric Needs in Rehabilitation, 60.

4 Celia Brody, "Helping a Client Move into Psychiatric Treatment," Diagnosis and Process in Family Counseling, FSA, New York, 114.

non-itemized social history, so that she may arrive at a tentative psychosocial diagnosis in order to determine the patient's ability to accept treatment and to prepare him for continued psychotherapy.[5] This statement was made by Futterman and Reichline and seems to be generally accepted by all writers in this field.

The part which the intake social worker plays in her relationship to the community patient was noted in the above discussion. We now should consider the psychiatric social worker's role in the clinic team. From intake through treatment planning the psychiatric social worker contributes to the understanding of the patient's emotional problems and his life situation. In addition she suggests areas in which psychiatric social work skills can be utilized in formulating treatment goals. This role is well demonstrated by the following statement made by Perlman.

> The generic characteristics of all teamwork, done in whatever setting, are these: (1) A common or joint goal is held by the persons working together; (2) these persons are come together because each has a special knowledge or skill or role in relation to the achievement of this common goal--that is, differing functions and ways of functioning are brought together for the joint purpose, and the team members must be clear about the respect the particular values which lie in those differences; (3) toward forming and maintaining cooperation among these several functionaries the social worker carries particular responsibility for the disciplined use of his understanding and of his ability to facilitate productive working relationships.[6]

---

5 Samual Futterman, M.D., and Philip B. Reichline, "Intake Techniques in a Mental Hygiene Clinic," Journal of Social Casework, XXIX, No. 2. February 1948, 49.

6 Helen Harris Perlman, "Generic Aspects of Specific Case-work Settings," Social Service Review, XXIII, No. 3, September 1949, 298.

Perlman further states:

> All settings, then, require teamwork of the social case worker, some consistently, some sporadically, some with roles fixed, others with roles shifting. But the understanding of that working relationship, the attitude toward it, and the skills in management of it are basic and generic and need, therefore, to be part of every case worker's professional equipment.[7]

The related literature distinctly points to the role of the psychiatric social worker in the intake process as a part of the entire psychotherapeutic relationship. The intake worker structures the basic elements of a productive clinic relationship in the initial interview by aiding the patient's understanding of both the therapist's and his own role in the treatment situation. The psychiatric social worker must bring to the clinic team the full use of her case work philosophy and techniques and utilize them in such a way as to make her contributions aid in the treatment, from the acceptance of the community patient to the final formulation of the treatment plan.

---

7 Ibid., 299.

CHAPTER II

SERVICES PROVIDED BY THE CLINIC

The Chicago Community Clinic functions as an all-purpose adult[1] mental hygiene clinic for out-patient care. It is operated for the communities in the Cook County area by the Mental Health Service of the Illinois Department of Public Welfare.[2] The clinic gives service primarily to residents of the Cook County area, but when requested by other divisions, institutions or agencies, offers its services to any resident of the state of Illinois.[3] Its primary function is rendering services to patients conditionally discharged from Illinois State Hospitals who return to the Chicago area. These conditionally discharged patients are routinely referred to the clinic by the state hospitals.[4] Services are also given to any former state hospital patient who requests help. By serving in this capacity the clinic is instrumental in preventing many of these people from returning to the state hospitals.

In addition to the above group of patients, service is given to

---

1 It accepts for treatment persons 18 years of age or over. However, those patients who are under 18 years of age are accepted if referred by a state hospital for supervision during the conditional discharge period.

2 Chicago Community Clinic, Annual Report, 1945-1946.

3 Chicago Community Clinic, Annual Report, 1946-1947.

4 Chicago Community Clinic, The Use of Funds in Safe-guarding Mental Health Should be considered an Investment Rather than an Expenditure, 1950.

community patients, that is, to individuals who never have been patients at state hospitals and who require psychiatric help. It is upon this last group of patients, who comprise a small percentage of the total number of patients seen at the clinic, that this study is focused.

The volume of the work of the clinic can be shown by statistics available for the most current fiscal year 1950-1951 which includes one year of the period covered by this study. The total number of patients seen at the clinic for that year is 3210. Included in this figure are 241 community patients[5] who comprise only thirteen percent of the total number of patients receiving service at the clinic.

The staff which handles this volume of work consists of three full time psychiatrists and one part time psychiatris. These psychiatrists are under the direct supervision of the superintendent of the clinic, a psychiatrist. The psychology department has eight full time psychologists and one part time psychologist who are under direct supervision of the chief psychologist. The social service department consists of a chief social worker, a director of state clinics, six case work supervisors and fourteen trained social workers. The entire social service staff is full time. The composition of the clinic staff follows the recommendations of the American

---

5 This figure taken from the Annual Report does not coincide with the statistics in footnote 1 which were obtained from the Clinic Logan community patients registered. This figure is higher because it includes brief social service contacts. During the period of this study these cases were counted in social service statistics but were not entered in the clinic log.

Psychiatric Association.[6] However, in relation to the volume of work, the shortage of clinic personnel is apparent.

In addition to the regular staff of psychiatrists, psychologists, and psychiatric social workers, there are other therapeutic services, such as: Occupational therapy, Recreational therapy and Physical education. These adjunctive forms of therapy are used to help the patient not only to learn to relate constructively to other people, but also to develop skills and abilities which fortify the patient's social relations.[7] All of these allied therapies are brought into the treatment situation upon the recommendation of the supervising therapist who is responsible for the individual patient.

The main function of this staff is servicing post psychotic patients who are routinely referred to this clinic by the various State Hospitals in Illinois. Recognizing the fact that the current trend in treatment is preventive rather than remedial, the clinic has set up the following standards of eligibility for those individuals designated as the community patients:

1) that the patient recognizes need for help and is willing to cooperate with the clinic program;
2) that he can benefit from what the clinic has to offer and
3) that the problem can best be met by psychiatric help.[8]

It has been the experience of the staff members of the clinic that

---

6 American Psychiatric Association Mental Hospital Service, Standards for Psychiatric Hospitals and Clinics.

7 Veterans Rehabilitation Center Program, phamplet.

8 Chicago Community Clinic, The Use of Funds in Safeguarding Mental Health should be Considered an Investment rather than an Expenditure.

the eligibility requirements as stated above are flexible enough to be of constructive use in the screening of community patients who present themselves to the clinic from various sources of referral. Patients are referred to this clinic by friends, relatives, family physicians, welfare agencies, psychiatric and medical clinics, and some are self motivated.

Upon the acceptance of the referral, an appointment is made for an intake interview with one of the psychiatric social workers. The intake interview attempts to establish a relationship which will lend itself to obtaining a generalized informal social history which will assist the treatment team in arriving at a tentative or provisional psychodynamic diagnosis for the purpose of determining the patient's ability to accept treatment.

Following the intake interview each case is discussed with a psychiatrist and only cases suitable for treatment are considered for acceptance. At this point the psychiatrist determines what additional diagnostic services are needed. The patient is then referred for the services indicated. When the diagnostic work is completed the case is then presented to the intake staff[9] for the formulation of a plan for treatment. At that point, the therapist, who may be a psychiatrist, a psychologist or a psychiatric social worker, is assigned to the case.[10]

---

9 The intake staff consists of psychiatrists, psychologists, psychiatric social workers and representatives from Recreational and Occupational therapy.

10 The intake procedure of the clinic is similar to the practices followed in other psychiatric clinics, according to a review of the related laterature. See Chapter I.

If it is determined, at any time during the intake process that the patient's needs are outside the scope and functions of the clinic, he is referred to an appropriate agency for further service.

As one might expect, the intake process involves the pooling of the activities and thinking of the psychiatric team and is time consuming. The amount of time given by the psychiatric social worker, the psychiatrist and the psychologist in seeing these patients is difficult to approximate, because it is obscured by the multiple demands on psychiatric time. The length of the interviews probably averages between 30 to 45 minutes. This point, however, is not always specified in the records. On the other hand, some of the interviews are shorter than 30 minutes, and others as long as an hour or more. The longer ones are, for the most part, with the psychiatric social workers at the point of intake, rather than with the psychiatrist.

The clinic offers a diagnostic or consultation service, which is differentiated from the treatment service. The criteria for differentiating the two types of service are as follows: a treatment case is one in which the clinic makes some attempt to deal with the patient's problem as such, and works directly with him for the purpose of effecting change in his feelings, relationships, or behavior; in a consultation service the clinic's role is limited to an examination. This examination is followed by a diagnostic report and/or interpretation of counsel, related to the patient's problem, which is given to referring agencies, to persons other than the patient, the family or the patient himself.

In summary, The Chicago Community Clinic functions as an all purpose adult mental hygiene clinic. The major function of the clinic is giving service to post psychotic patients. A secondary function is servicing the community patients. The staff is composed of psychiatrists, psychologists, and psychiatric social workers who function as a team, and evaluate those cases accepted through the intake process. Some of these cases are given consultation service only, while others are accepted for treatment.

CHAPTER III

FACTORS RELATED TO EFFECTIVE TREATMENT

The purpose of this study is to determine the factors which seem to be significantly related to effective treatment. The study is based on the case histories of forty-four community patients who received psychiatric treatment at the Chicago Community Clinic from July 1947 through June 1951.

The purpose of this study can also be stated as an attempt to answer the following questions: 1) How many of these cases were treated effectively; and 2) What factors were present in the effectively treated cases which were absent in the ineffectively treated?

The first question, though of supreme importance, will be treated with comparative brevity, since the focus of this study is on the second question.

The method employed in getting an answer to the first question is as follows:

1) A set of criteria for evaluating effectiveness of treatment was adopted. These criteria are patterned after those used by the New York Committee on Mental Hygiene.[1] Improvement

---

1 New York City Committee on Mental Hygiene, The Functioning of Psychiatric Clinics in New York City, 1949, 7.

in one or more of the following areas of behavior is considered indicative, though not probative, of effective treatment:

a) Social relationship

b) Occupation

c) The psychiatric problem

2) The case histories of forty-four patients were scrutinized for indications of improvement in any of these three areas. If improvement was found, the clinic treatment was assumed to be responsible for the patient's gains. Whether the improvement was in terms of overt change of behavior or of increased insight, whether great or slight, it was assumed to be indicative of the clinic's effectiveness in helping the patient.

Employing this method, the writer found that improvement in the patient's behavior in at least one of these areas was indicated in 22 of the forty-four cases. In these cases, therefore, evidence of the effectiveness of the treatment process was recorded in the histories. It does not follow conclusively, however, that the treatment was ineffective in the other twenty-two cases, because case recordings cannot be presumed to contain a complete story. Whatever is contained in the recording may be presumed to be true and valid, but it would be unrealistic to presume that what is not contained in the record actually did not happen. Case recording

is not a verbatim account; rather it is a report usually made from memory. The absence of a fact in the recording would hardly be valid evidence that the fact never transpired.

The number of effectively treated patients, therefore, may actually be higher than twenty-two. But, since the purpose of this study is to determine the factors which seem to accompany effective treatment, it is sufficient to identify the cases which were effectively treated without proving that the remaining were ineffectively treated.

For purposes of this study, however, for want of more accurate terminology, the latter group will be termed "ineffectively treated."

Before proceeding to the second question, "What factors were present in the effectively treated cases?" some indication will be given of the areas of improvement in the twenty-two successful cases.

Table I shows that eleven patients had shown improvement in their relationships with member of their families or friends; no change was noted in eleven patients. Ten patients were able to form new friendships and initiate new activities; it does not necessarily mean that in the case of the other twelve patients there was no change in any area. The social relationships may not have been the area in which the patient's needed adjustment. However, certain changes were noted and recorded in other phases of the patient's functioning.

TABLE I

RESULTS IN RESPECT TO SOCIAL RELATIONSHIPS OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT

Criteria	Change		Total
	Yes	No	
Change in relationships between patient and family or friends	11	11	22
Initiation of New friendships and activities	10	12	22

In Table II, which discusses the changes in the areas of occupation of these twenty-two patients, we find a decided difference in the statistical distribution. Fourteen patients were able to change from a status of unemployment to one of employment, eight were not. Only one patient out of twenty-two changed from a poorer to a better job. One patient seemed to have adjusted well enough to be able to receive an increase in salary. The emphasis in this clinic is to make employment an outcome of treatment, not a goal in itself. At the beginning of therapy nineteen patients were unemployed. The three patients who were employed remained functioning satisfactorily in their current employment. They held their job and did not bring out problems in therapy relative to the job.

TABLE II

RESULTS IN RESPECT TO OCCUPATION OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT

Criteria	Change		Total
	Yes	No	
Change from unemployment to employment	14	8	22
Change from poorer to better job	1	21	22
Related change	1	21	22
Increased salary	1	21	22
Increased responsibility	0	22	22

Table III indicates that four patients manifested a greater tolerance of symptoms after treatment. In fifteen cases the patients showed a lessening or total disappearance of symptoms. It is interesting to note that in nine cases the patients had developed some degree of insight into their psychiatric problem. However, in only two cases was it considered that the patient made an apparent recovery.

TABLE III

RESULTS IN RESPECT TO PSYCHIATRIC PROBLEM OF TWENTY-TWO PATIENTS RECEIVING EFFECTIVE TREATMENT

Criteria	Change		Total
	Yes	No	
Greater tolerance of symptoms	4	18	22
Lessening or disappearance of symptoms	15	7	22
Development of insight	9	13	22
Apparent recovery	2	20	22

In order to show a composite picture of the changes in the twenty-two patients effectively treated the items in Tables I, II, and III have been assembled in Table IV. It does not seem practical to describe all the points used in the criteria since there are so many variables. Following a patient across the table itself gives a clear picture of the changes which occurred.

Table IV shows that sixteen showed change in social relationships; fifteen patients showed change in employment and, twenty-one patients showed change in the psychiatric problem. Ten patients showed change in all three areas used in the criteria. Six patients showed change in social relationships and the psychiatric problem. Four patients showed change in employment and the psychiatric problem. One patient changed only in the area of employment, and one patient showed change in the psychiatric problem only.

The most significant point which Table IV illustrates is that twenty-one out of the twenty-two patients experienced a change in the psychiatric problem. Whenever a change was noted in this area, changes also occurred in the other two areas, that is, social relationships and employment.

TABLE IV

COMPOSITE PICTURE OF TABLES I, II AND III

Patients	Table II Social Relationships		Table III Employment			Table IV Psychiatric Problem				Total Changes
	1	2	1	2	3	1	2	3	4	
1	ϕ	o	ϕ	o	o	ϕ	o	ϕ	o	4
2	ϕ	o	ϕ	o	o	o	ϕ	o	o	3
3	ϕ	ϕ	o	o	o	o	ϕ	ϕ	ϕ	5
4	o	o	o	o	o	o	ϕ	o	o	1
5	ϕ	o	ϕ	o	o	o	ϕ	ϕ	o	4
6	ϕ	ϕ	ϕ	o	o	o	ϕ	o	o	4
7	o	ϕ	o	o	o	o	ϕ	o	o	2
8	ϕ	o	o	o	o	o	ϕ	ϕ	o	3
9	o	o	ϕ	o	o	o	o	o	o	1
10	ϕ	ϕ	o	o	o	o	ϕ	ϕ	o	4
11	o	ϕ	o	o	o	o	ϕ	o	o	2
12	ϕ	ϕ	ϕ	o	ϕ	o	o	ϕ	o	5
13	o	o	ϕ	o	o	ϕ	o	o	o	2
14	o	ϕ	ϕ	o	o	o	ϕ	o	o	3
15	o	ϕ	o	o	o	o	ϕ	o	o	2
16	ϕ	ϕ	ϕ	o	o	ϕ	o	o	ϕ	5
17	o	ϕ	o	ϕ	o	o	ϕ	ϕ	o	4
18	ϕ	o	ϕ	o	o	o	ϕ	o	o	3
19	o	o	ϕ	o	o	ϕ	o	o	o	2
20	o	o	ϕ	o	o	o	ϕ	o	o	2
21	o	o	ϕ	o	o	o	ϕ	o	o	2
22	ϕ	o	ϕ	o	o	o	ϕ	o	o	3

o No change
ϕ Change

We now proceed to the second question, "What factors were commonly present in the effectively treated cases?" All the data available in the case histories were recorded on the Schedule (See Appendix). They included the personal characteristics of the patients, the methods of referral; the effectiveness of the intake process both in individualizing patient and helping him to verbalize his problem and to evaluate the patient's motivation for the treatment; the evaluation of treatability in relation to diagnostic categories; the duration of treatment, and the nature of termination of the patient-clinic contact. A presentation of these factors will now be made.

The personal characteristics of the patient group offer relatively few clues either for explaining the effectiveness of treatment. In this study little significance can be attributed to the sex, employment status, occupation, education and marital status of the patients. There is somewhat clearer evidence, however, that the clinic has a higher rate of success with patients in their late twenties and early thirties. These findings do not agree with those of the New York City Committee on Mental Hygiene, who found, in a similar study, that the rate of effective therapy was higher with patients in their late thirties and early forties.[2] The reason for this variation in the age groups as related to effective therapy may be due

---

2 New York City Committee on Mental Hygiene, The Functioning of Psychiatric Clinics in New York City, 1949, 12

to the smaller sample of patients who comprise this study group. However, too many variables enter this picture to make it a reliable one or to permit further exploration on the basis of the data available.

Table V shows that a little more than half of the treated group of patients were self-referred. This seems to coincide with findings made by Blenkner, Hunt, and Kogen in a study of intake, who state that 60 percent of their study group applied for service personally.[3] Since the percentage of patients receiving effective treatment as related to the source of referral in Table V shows only a small range of variation, a valid conclusion cannot be drawn.

---

3 Margaret Blenkner, J. McV. Hunt, and Leonard S. Kogan, "A Study of Interrelated Factors in the Initial Interview with New Clients" Social Casework XXXII No. I, January 1951, 23

TABLE V

SOURCES OF REFERRAL

Sources of Referral	Number of Patients Effectively Treated	Number of Patients Ineffectively Treated
Physicians	1	1
Psychiatrists and other psychiatric services	4	4
Case work agencies	3	1
Patient himself	11	12
Individuals other than patient	3	4
Totals	22	22

However, a study of the case records reveals that the patients referred by social agencies and psychiatric services come somewhat better prepared than those referred by other sources. Here the referring person is usually a trained social case worker from whom the patient received interpretation regarding the functions of the clinic and who also furnishes the clinic with information about the patient.

Significantly influencing the effectiveness of therapy is the patient's motivation and reason for coming to the clinic. The patient must realize the nature of his problem and the nature of the help the clinic can offer. The relationship of this to effective help shows that those patients

who understand the nature of their problem tend to be helped and continue coming to the clinic for treatment.

The patient's purpose in accepting referral to the clinic is significantly related to his prospects of effective therapy. Of the forty-four treated patients whose motives could be determined from the case records only twenty-three had sought the clinic as a source of actual treatment and with this group the clinic had a maximum success, a fifty-two percent rate of effective therapy. The other twenty-one patients, whose motives for coming to the clinic could be analyzed, came with little awareness of their problems or incentive toward dealing with them. Some came at the insistence of physicians, social agencies or relatives. Others sought relief from physical symptoms. Some wanted advice on practical plans and some came with confused notions about the clinic and its ability to help them.

Table VI shows the relationship between the patient's view of his problem and the effectiveness of treatment.

TABLE VI

PATIENTS VIEW OF HIS PROBLEM AS RELATED TO EFFECTIVENESS OF TREATMENT

Problem	Number of Patients Effectively Treated	Number of Patients Ineffectively Treated
Primarily emotional	14	7
Primarily physical	6	8
In other terms	2	7
Totals	22	22

The patient's reason for coming to the clinic and his view of his problem are closely related to continuance of treatment. If a patient is unprepared to find psycho-therapy offered for what he regards as a physical symptom or an employment problem, he may drop out of treatment. The frame of mind in which the patient comes, and the readiness for active cooperation in therapy in many instances is determined by the referral process. The interpretation to the patient at the point of intake is also of importance.

As with the personal history data, the findings with regard to diagnostic classification do not lend themselves to explaining the reasons for the effectiveness of treatment. The largest diagnostic group was that included under psychoneurosis. The effective treatment rate is higher for anxiety neurosis than for any other category in the diagnostic group.

These findings concur with the New York City on Mental Hygiene study.[4]

TABLE VII

DISTRIBUTION OF FORTY-FOUR TREATMENT CASES ACCORDING TO DIAGNOSTIC TYPE AND RATE OF EFFECTIVE SERVICE

Diagnostic Group	No. of Patients Effectively Treated	No. of Patients Ineffectively Treated	Percentage Effectively Treated	Percentage Ineffectively Treated	Total
Psychosis					
Schizophrenia	5	4	60%	40%	100%
Manic Depression	1	1	50	50	100
Other Types	1	4	20	80	100
Psychoneurosis					
Anxiety Group	6	2	75	25	100
Other Types	9	11	45	55	100
Totals	22	22			44

An important factor in the effectiveness of any psychiatric service is the stability of the clinic-patient relationship. The patient cannot be helped if he is not sufficiently motivated or receptive toward actively cooperating or participating in the therapeutic situation.

---

4 New York City Committee on Mental Hygiene, "The Functioning of Psychiatric Clinics in New York City," 1948, 12

The regularity and frequency of clinic appointments was found to be a significant factor in determining the effectiveness of help which the patients in the study group received.

The number of clinic visits by the patient which were necessary for perceptible improvement varies with different patients. From the data available in the case records a rough minimum can be established. The records give evidence that while patients in this group were not helped in less than five visits, many were helped with as few as seven interviews; in general, sustained contact appears to increase the likelihood of effective help.

Table VIII indicates that while five visits may be considered the minimum for effective help, one-fourth of the treated patients (eleven) came to the clinic fewer than five times. This group included one-half of the clinics failures. Almost half (nineteen) made fewer than ten visits, while seventeen patients made more than fifteen.

The success of treatment is very high for patients (ten) who made over twenty visits. Peak records in terms of time span plus frequency of appointments were those of two pateints who made fifty-six and seventy-one visits respectfully over periods of eight and twelve months. These patients were both in the successfully treated group.

TABLE VIII

FREQUENCY OF CLINIC VISITS MADE BY 44 TREATED PATIENTS

Number of Visits to the Clinic	Number of Patients Effectively Treated	Number of Patients Ineffectively Treated
1 to 4	0	11
5 to 10	5	4
11 to 15	4	3
16 to 20	3	2
21 or more	10	2
Total	22	22

With reference to those patients who made fewer than five visits to the clinic the following factors might have been significant. In the earlier years of the study there was a long waiting list (due to shortage of staff following the war years), and patients had to wait between application for service, the intake interview and the assignment of a therapist. The present procedure of the clinic is to assign the patient to a therapist within a week or two following the intake interview. In emergency situations the patient is immediately referred to a psychiatrist for evaluation and/or treatment. Another factor which might have influenced the dropping out of patients was a change in therapists. In addition, the four or less interviews may represent exploration rather than treatment per se. A fourth

possibility might have been that the patient was not a good treatment prospect and discontinued coming to the clinic. The status of therapist-patient relationship during initial interviews may not have been secure, resulting in the patient's self withdrawal from clinic contact. The fifth possibility is the patient's motivation for treatment was not sufficient to maintain contact with the clinic, although every effort is made to evaluate the patient's motivation during the intake interview.

The most frequent way for the contact between the patient and the clinic to end is for the patient to terminate without notice. In over half of the treated cases, the patient merely failed to keep an appointment and then never returned. Usually one, sometimes two letters are sent to the patient, offering an appointment.

TABLE IX

MANNER OF TERMINATING PATIENT-CLINIC CONTACT, AS RELATED TO EFFECTIVENESS OF TREATMENT

Number of Visits to the Clinic	Effectively Treated		Ineffectively Treated	
	Self Terminated	Other Terminated	Self Terminated	Other Terminated
1 to 4	0	0	11	0
5 to 7	3	0	3	0
8 or more	10	9	4	4
Total	22		22	

The positive correlation between self termination and effective therapy is obvious in Table IX. Of the twenty-two patients who were effectively treated the clinic determined the closing in the case of nine patients. Three who were effectively treated discontinued contact after five to seven interviews and ten after eight or more interviews. Of the twenty-two patients that were considered ineffectively treated, eighteen terminated contact themselves. Fourteen of these patients were seen less than seven times, and the four who were closed by the clinic had been seen at the clinic for eight or more interviews.

In summary, the factors which seem to have related to effectiveness of treatment are: methods of referral; the patient's formulation of his problem and his motivation for treatment; treatibility in relation to the diagnostic categories; the duration of treatment, and the nature of termination of the patient-clinic contact.

SUMMARY AND CONCLUSIONS

This study is based on an analysis of the case records of forty-four community patients known to the Chicago Community Clinic from July 1947 through June 1951. The study attempted to identify the factors which seemed to be significantly related to effective or ineffective therapy.

The study showed that the personal characteristics of the group offered no clues either for explaining the effectiveness of treatment. The significant factors were found in the following areas: sources of referral, the patient's formulation of his problem, the diagnostic categories and the duration of treatment.

Since the clinic is understaffed in relation to the volume of work, a more efficient use of its facilities and time could be made by a more careful screening of patients at the point of referral. There is evidence of unnecessary waste of psychiatric time due to faulty referrals and a misconception of the clinic functions by the referring source. The records show that those patients who were referred by social agencies and psychiatric services, where the referring person was usually a social worker, came better prepared and better able to use effectively the services which the clinic offers.

Similarly in those cases where the patient formulates his problem as being on an emotional basis the rate of effective service is greater.

Further, the study shows that the more serious disorders, particularly psychotic conditions, do not show measurable results in the scope of short term therapy. The clinic experienced the highest percentage of effective service with patients diagnosed as psychoneurosis, anxiety type.

With reference to duration of treatment, those patients who broke off treatment in less than five interviews seem to have received no effective help. The success of treatment was progressively higher for patients who continued coming to the clinic. This was particularly true for patients who made eight or more visits to the clinic.

BIBLIOGRAPHY

American Psychiatric Association Mental Hospital Service, "Standards for Psychiatric Hospitals and Clinics," Washington D. C., November, 1951

Austin, Lucille, "Trends in Differential Treatment in Social Case Work," Journal Social Case Work, XXIX No. 6, June 1948, 203-212

Bibring, Grete L., "Psychiatric Principles in Casework," Journal Social Casework, XXX No. 6, June, 1949, 230-235

Body, Celis, "Helping a Client Move into Psychiatric Treatment," Diagnosis and Process in Family Counseling, New York, 1951, 90-120

Burns, Margaret, M. and Prados, Miguel, "Psychotherapeutic Aspects of the Psychiatric Social Worker's Role in a Psychiatric Out-Patient Clinic," Journal Psychiatric Social Work, XX No. I, September, 1950, 29-34

Chapman, Catherine, "Some Casework Techniques Necessary in Referring Clients to Psychiatric Clinics," Journal Psychiatric Social Work, XX No. I, September, 1950, 11-17

Chicago Community Clinic, "The Use of Funds in Safeguarding Mental Health Should Be Considered an Investment Rather Than an Expenditure," 1950

Coleman, Jules V., "Distinguishing Between Psychotherapy and Casework," Journal Social Casework, XXX No. 6, June, 1949, 244-251

Futterman, Samuel and Richline, Philip B., "Intake Techniques in a Mental Hygiene Clinic," Journal Social Casework, XXIX No. 2, February, 1948, 49-56

Goldman, Rose, "The Psychiatric Social Worker's Treatment Role", Journal Psychiatric Social Work, XX, December, 1950, 65-68

Group for the Advancement of Psychiatry, "Psychiatric Social Work in the Psychiatric Clinic," No. 16, September, 1950

McClure, Dorthea, "Intake in a Child Guidance Center," Family, XXI, No. 8, December, 1940

New York City Committee on Mental Health, "The Functioning of Psychiatric Clinics in New York City, A Study Toward Prevention of Waste," New York, 1949

New York City Committee on Mental Health, "The Functioning of Psychiatric Clinics in New York City, Psychiatric Needs in Rehabilitation," New York, 1948

Perlman, Helen Harris, "Generic Aspects of Specific Case-Work Settings," Social Service Review, XXII No. 3, September, 1949, 302-314

Veterans Rehabilitation Center, "Veterans Rehabilitation Center Program," 1950

Rockmore, Myron John, "Case Work Today in a Psychiatric Setting," Journal Psychiatric Social Work, XXI, September 1951, 26-33

Rockmore, Myron John, "Social Case Work as Therapy," Journal Psychiatric Social Work, XXIII, No. 4, April 1949, 182-190

Varon, Edith and Maas, Henry S., "Evaluating Social Adjustment Through a Systematic Study of Interpersonal Relationships," Journal of Psychiatric Social Work, XXI, September, 1951, 17-25

CASE NUMBER _____

1. AGE ____ 2. SEX ____ 3. MARITAL STATUS ____ 4. EDUCATION _____

5. OCCUPATION _____

6. SOURCE OF REFERRAL _____

7. DATE OF INTAKE _____ 8. DATE OF CLOSING _____

9. INTAKE INTERVIEWER _____

10. PROBLEM PRESENTED BY PATIENT AT INTAKE: 11. STAFF DIAGNOSIS _____

_____ _____

_____ _____

_____ _____